

09358

CERTIFICATE OF DEATH

09357

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN 1b 12 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Wyatt Acton		4. DATE OF DEATH Month 7 Day 25 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-96
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		9b. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Acton	
14. MOTHER'S MAIDEN NAME C. Gertrude Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 212-12-5115		17. INFORMANT Elizabeth L. Acton, North Beach, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 24 , 19 67 , to July 25 , 19 67 that (I) (we) last saw the deceased alive on July 25 19 67 , and that death occurred at 12:15 p.m. from causes and on the date stated above.			
22a. SIGNATURE George J. Weems, M.D.		22b. DATE SIGNED 7/25/67	
22c. PHYSICIAN'S NAME (Type) George J. Weems, M.D.		22d. ADDRESS Huntingtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 28, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR JUL 28 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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09359

CERTIFICATE OF DEATH

09358

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick c. LENGTH OF STAY IN lb 56 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Lusby d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Duke Adams		4. DATE OF DEATH Month Day Year 7 11 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-82
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Adams	
14. MOTHER'S MAIDEN NAME Ella Duke		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I.	
16. SOCIAL SECURITY NO. 212-10-2536		17. INFORMANT Address Martha Adams Lusby, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x C.V.A. - Noni - plegia DUE TO (b) coma DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 22, 1964 , to July 11, 1967 that (I) (we) last saw the deceased alive on July 11, 1967 , and that death occurred at 520am , from causes and on the date stated above.			
22a. SIGNATURE Issam F. el Damalouji, M.D.		22b. DATE SIGNED 7/11/67	
22c. PHYSICIAN'S NAME (Type) Issam F. el Damalouji, M.D.		22d. ADDRESS Prince Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Easton, Talbot, Md.
24. FUNERAL DIRECTOR A.A. Harkness Son - Port Republic, Md.		25. REC'D BY REGISTRAR JUL 13 1967	
25b. REGISTRAR'S SIGNATURE J. Harkness			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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SP-11-11

09359

09360

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~card~~ pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick				c. LENGTH OF STAY IN TB 6 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Owings	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mazie Middle Ellen Last Booze				4. DATE OF DEATH Month 7 Day 21 Year 1967			
5. SEX female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-90	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel Coates				14. MOTHER'S MAIDEN NAME Mary Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James Booze Address Owings, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cav 7 Breast DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 7/2 , 19 67 , to 7/21 , 19 67 , that (I) (we) lost the deceased alive on 7/21 , 19 67 , and that death occurred at 2:15 PM , from causes and on the date stated above.							
22a. SIGNATURE Roberto de Villarreal M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M.D.	
22d. ADDRESS St. Leonard, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7-24-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope C. Cem		23d. LOCATION (City or Town) (County) (State) Sunderland Cal. Md.	
24. FUNERAL DIRECTOR Pinkney E. Sewell ADDRESS Prince Frederick				25a. REC'D BY REGISTRAR JUL 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09361

CERTIFICATE OF DEATH

09360

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick			c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-St. Leonard		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanche E Cox				4. DATE OF DEATH Month 7 Day 25 Year 1967			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-82	
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hatton				14. MOTHER'S MAIDEN NAME Mary Padgett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579-62-5635		17. INFORMANT Address Minerva Herbert St. Leonard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart Dis. (c) Arteriosclerotic heart Dis.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 14, 1967 to July 25, 1967 that (I) (we) last saw the deceased alive on 7/25/67 and that death occurred at 12:54 P.M. from causes and on the date stated above.							
22a. SIGNATURE Osman Z. Ersoy, M.D.				22b. DATE SIGNED 7-25-67		22c. PHYSICIAN'S NAME (Type) Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-28-1967		23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION (City or Town) (County) (State) Wash, D.C.	
24. FUNERAL DIRECTOR Robert A. Mattingly				25a. REC'D BY REGISTRAR DATE JUL 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Stuart, Md.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Broomes Island</i>	
3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Stuart</i>		d. STREET ADDRESS <i>Stuart</i>	
3. NAME OF DECEASED (Type or print) <i>Michael</i>		4. DATE OF DEATH Month <i>7</i> Day <i>23</i> Year <i>1987</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15 1948</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Wilburn Denton</i>		14. MOTHER'S MAIDEN NAME <i>Jean E. Poffenbarger</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-48-3787</i>	
17. INFORMANT <i>Wilburn Denton, Broomes Island Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured skull</i> 8254 DUE TO (b) <i>both legs and chest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Auto accident</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Auto accident</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hit by car</i>		20c. TIME OF INJURY Month, Day, Year Hour <i>7:30</i> p.m. <i>7/23/67</i>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	
20f. (City or town) <i>Calvert</i>		(County) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward, Owings, Md.</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <i>7/23/67</i>	
Address (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>July 27, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Christ Church Cemetery</i>	
23d. LOCATION (City, town or county) <i>Port Republic</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>A. G. Harkness & Son, Port Republic, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 27 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

For the purpose of the above

Only one

Chad Lee

Wm. L. M.

7/3/75

Amberly

CERTIFICATE OF DEATH

09362

362

1. PLACE OF DEATH
a. COUNTY Calvert County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach, Md.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert Co. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md.
b. COUNTY Lusby, Md.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)
First Middle Last
Jesse Elmer Fridley

4. DATE OF DEATH
Month Day Year
July 11 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH
12/2/1902

9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT
Address
Mrs John Leach Lusby, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a),
Cardiac failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/12 1966 to 7/11 1967, that (I) (we) last saw the deceased alive on 7/11 1967, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE G. J. Weems M.D.
22b. DATE SIGNED 7/11/67
22c. PHYSICIAN'S NAME (Type) G. J. Weems
22d. ADDRESS Huntingtown Md

23a. BURIAL, CREMATION REMOVAL (Specify) Burial
23b. DATE THEREOF 7/14/67
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill
23d. LOCATION (City, town or county) (State) Suitland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE
Lee Funeral Home, Washington, D. C.
ADDRESS

25a. REC'D BY REG. STRAR JUL 14 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <i>Calvert</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <i>Maryland</i> b COUNTY <i>Calvert</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i> LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>	
3 NAME OF DECEASED (Type or print) <i>James Edward Green</i>		4 DATE OF DEATH Month <i>7</i> Day <i>31</i> Year <i>1967</i>	
5 SEX <i>M</i>	6 COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Jan 1905</i>
10a USUAL OCCUPATION (Give kind of work done during most of work in life, even if retired) <i>Iron Works</i>		11 BIRTHPLACE (State or foreign country) <i>MD</i>	
12. FATHER'S NAME <i>James Green</i>		14. MOTHER'S MAIDEN NAME <i>Madra Hall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16 SOCIAL SECURITY NO <i>220-16-4367</i>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>10-17</i> (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>found unconscious and died on way to H</i>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year <i>7-31-1967</i>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, hospital, street, office, etc.) <i>Home</i>	20f (City or town) <i>Sunderland</i> (County) <i>Calvert</i> (State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H W Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H W Ward</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>7/31/67</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>8-3-67</i>		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY <i>Mt. Hope Ch. Cem</i>		23d LOCATION (City or Town) <i>Sunderland</i> (County) <i>Cal.</i> (State) <i>Md</i>	
24 FUNERAL DIRECTOR <i>Linken E. Sowell</i>		ADDRESS <i>Prince Frederick Md</i>	
25a REC'D BY REGISTRAR <i>AUG 3 1967</i>		25b REGISTRAR'S SIGNATURE <i>James E. Sowell</i>	



09365

CERTIFICATE OF DEATH

00304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>(rural)</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Emory</u> Last <u>Howard</u>				4 DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>19 67</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 6, 1877</u>	9 AGE (In years last birthday) <u>89</u> yrs	10 IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>		11 IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State or foreign country) <u>Calvert Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Howard</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Pitcher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>219-46-5768T</u>		17. INFORMANT <u>Mrs. Nora E. Howard, Port Republic, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u> DUE TO (b) <u>Cerebral sclerosis</u> DUE TO (c) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sudden</u> , 19 <u>—</u> , to <u>—</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that death occurred at <u>—</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. DEUILLARD, M.D.</u>				22d. ADDRESS <u>57 Harbor, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Water's Memorial Center, St. Leonard, Calvert, Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>A.G. Harkness & Son, Port Republic, Md.</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

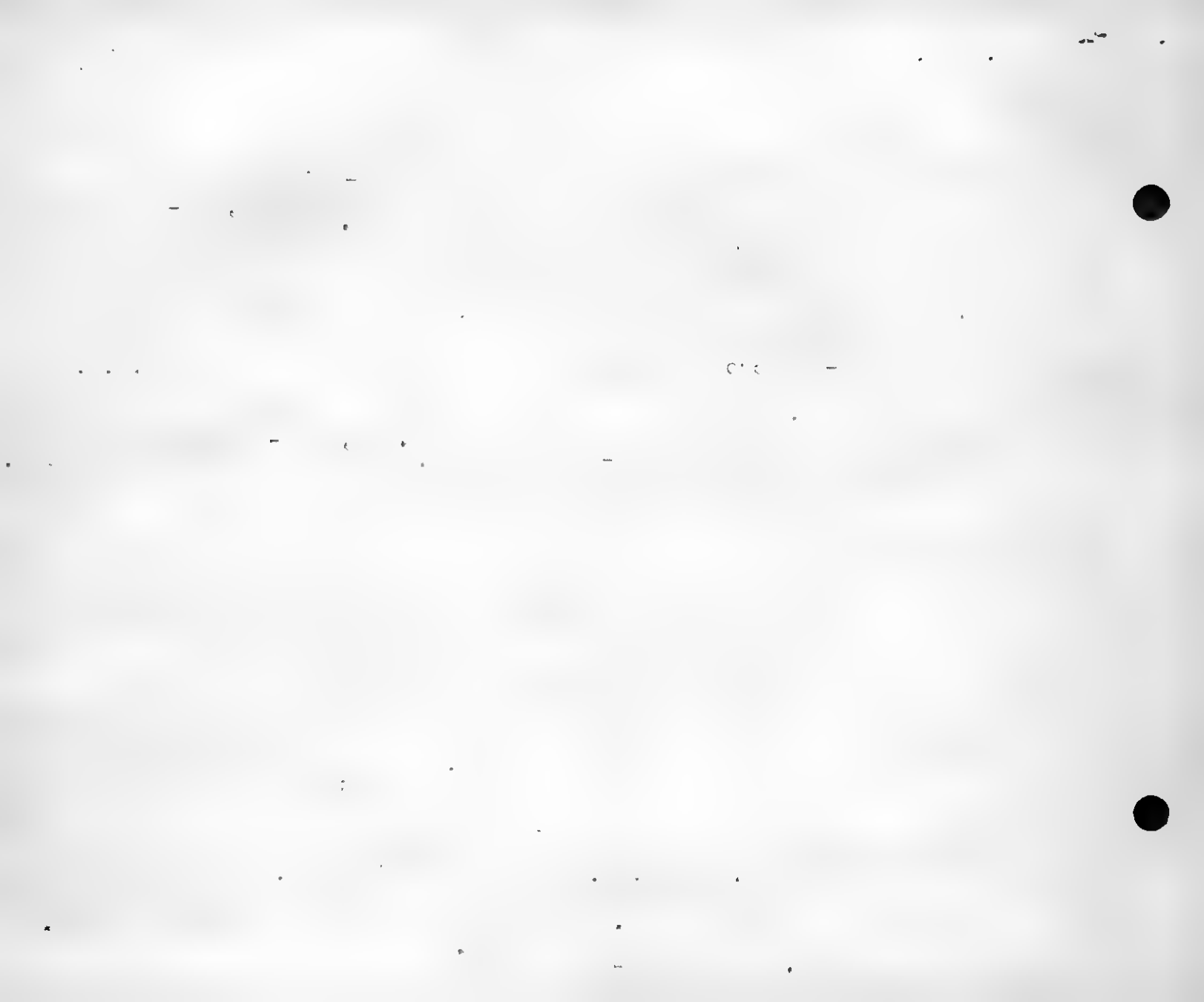
3365

09366

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Calvert MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c LENGTH OF STAY IN TB 8 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e STREET ADDRESS Route #102, Clay-Hammond Rd. 20678	
3 NAME OF DECEASED (Type or print) First Middle Last Joseph Samuel Kidwell		4 DATE OF DEATH Month Day Year 7 3 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-98
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Tobacco		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Kidwell		14. MOTHER'S MAIDEN NAME Lizzie Richards	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO 212-12-0479	
17. INFORMANT Mary E. Kidwell Prince Frederick, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of Lung DUE TO (b) DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1966 , to July 3, 1967 that (I) (we) last saw the deceased alive on July 3, 1967 , and that death occurred at 11:00 p.m. , from causes and on the date stated above.			
22a. SIGNATURE George J. Weems, M.D.		22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) George J. Weems, M.D.		22d. ADDRESS Huntingtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/7/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	23d. LOCATION (City or Town) (County) (State) Upper Marlboro Md.
24. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Upper Marlboro		25a. REC'D BY REG. STRAR JUL 11 1967	
25b. REG. STRAR'S SIGNATURE John L. George			



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00367

CERTIFICATE OF DEATH

00366

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN TB 25 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) First Middle Last Emily Gertrude Leitch				4. DATE OF DEATH Month Day Year July 9 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-76	9. AGE (In years lost birthday) 90 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Colton				14. MOTHER'S MAIDEN NAME Helen Vander Warker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-42-0886		17. INFORMANT Address Helen Jarvis, Huntingtown, Maryland			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Decompression DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Art. del. C.V. disease DUE TO (c) Repeated Expenditures							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 12, 1967 to July 9, 1967 that (I) (we) lost saw the deceased alive on July 9, 1967 , and that death occurred at 7:42 P.M. from causes on and on the date stated above							
22a. SIGNATURE Page C. Jett, M. D.				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/11/67	
22c. PHYSICIAN'S NAME (Type) Page C. Jett, M. D.				22d. ADDRESS Prince Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Delaware Cemetery		23d. LOCATION (City or Town) (County) (State) Sunderland, Calvert, Md.	
24. FUNERAL DIRECTOR A.A. Herskess, Son, Port Republic, Md.				25a. REC'D BY REGISTRAR DATE JUL 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

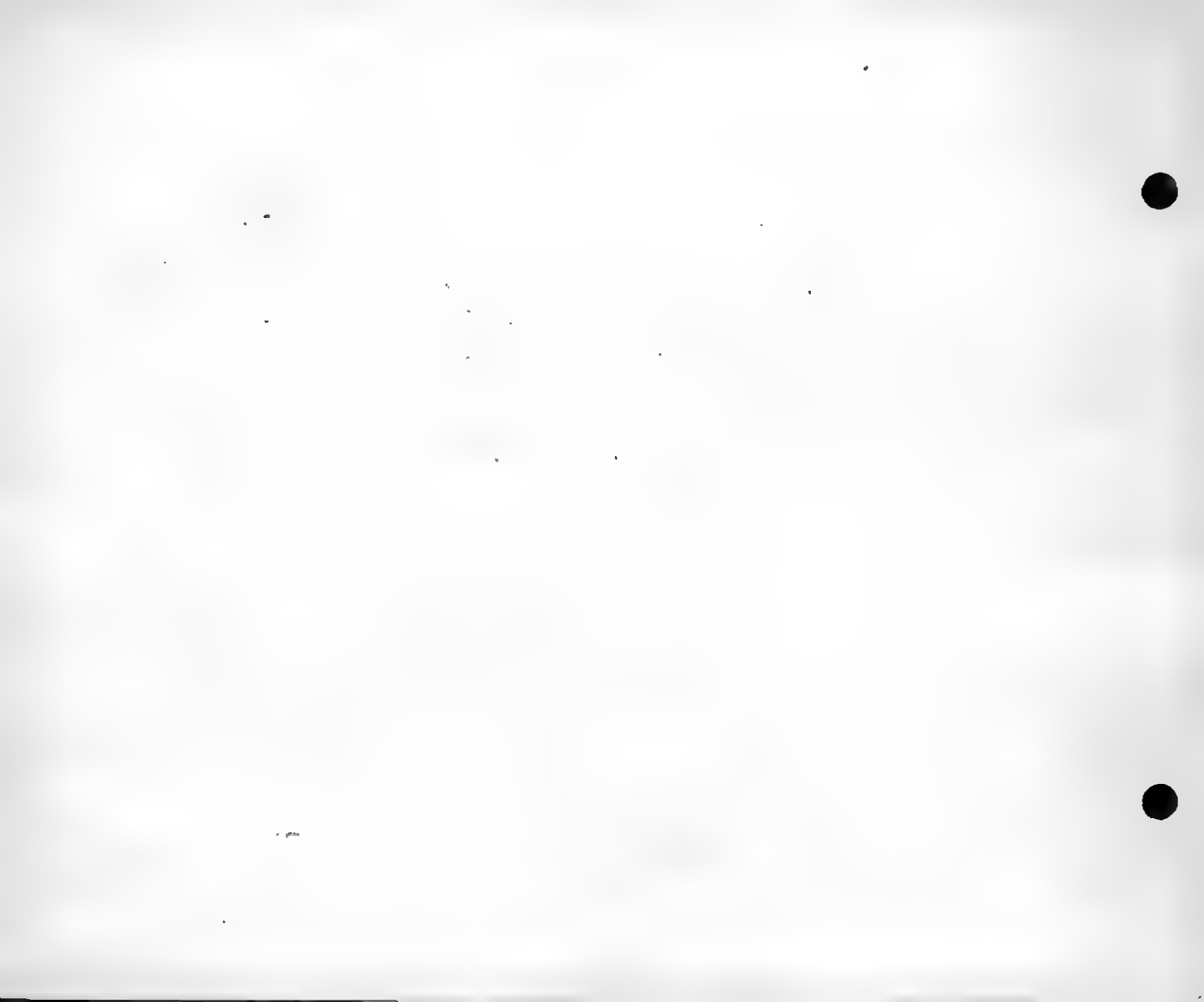
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09368

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09367

1 PLACE OF DEATH a COUNTY <u>Calvert</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Res. death before admission) a STATE <u>DC</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>C.C. Hospital</u>		d STREET ADDRESS <u>18 St, NW</u>	
3 NAME OF DECEASED (Type or print) <u>Amador</u>		4 DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 1, 1941</u>
9 AGE (in years last birthday) <u>22</u> yrs		10 UNDER 1 YEAR Months <u>1</u> Days <u>22</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tree Nursery</u>		10b KIND OF BUSINESS OR INDUSTRY <u>PUERTO RICO</u>	
11 BIRTHPLACE (State or foreign country) <u>PUERTO RICO</u>		12 CITIZEN OF WHAT COUNTRY? <u>PUERTO RICO</u>	
13 FATHER'S NAME <u>DOMINGO LUGO</u>		14 MOTHER'S MAIDEN NAME <u>DOLORES MONTALVO</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> <u>UNKNOWN</u>		16 SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17 INFORMANT <u>Tony Garcia</u>		Address <u></u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Resem</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u>			
(c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was swimming at Benedict with other</u>			
19 WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Was mugged and found floating</u>	
20c TIME OF INJURY Month, Day, Year <u>3/5 - 7 23 67</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>at work</u>	
20e PLACE OF INJURY (home, farm, factory, street, office, bldg, etc.) <u>Calvert</u>		20f CITY OR TOWN <u>Benedict</u> County <u>Calvert</u> (State) <u>MD</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u></u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7/27/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Burial</u>		23d LOCATION (City or Town) (County) (State) <u>Force, Puerto Rico</u>	
24 FUNERAL DIRECTOR <u>W. W. CHAMBERS Co. - Washington, DC.</u>		25a REC'D BY REGISTRAR <u>J. Charles Young</u>	
ADDRESS <u></u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Young</u>	
		DATE <u>JUL 28 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

93368

1 PLACE OF DEATH a. COUNTY Calvert MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c LENGTH OF STAY IN TB 13 hrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e STREET ADDRESS Chesapeake Beach	
3 NAME OF DECEASED (Type or print) Annie Pearl Mangum		4. DATE OF DEATH Month 7 Day 6 Year 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 2-7-89
9 AGE (In years last birthday) 78 yrs		10 UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher C. Hayes		14. MOTHER'S MAIDEN NAME Lucinda M. Beatley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 577-36-6754	
17. INFORMANT Edna Mangum		Address Chesapeake Beach, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) arteriosclerotic heart dis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from April 19, 1966 to July 6, 1967 , that (I) (we) last saw the deceased alive on July 6, 1967 , and that death occurred 01:30 AM , from causes on and on the date stated above.			
22a. SIGNATURE Osman Z. Ersoy, M.D.		22b. DATE SIGNED 7/7/67	
22c PHYSICIAN'S NAME (Type) Osman Z. Ersoy, M.D.		22d. ADDRESS Prince Frederick, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF July 8, 1967	23c NAME OF CEMETERY OR CREMATORY Epiphany Cem	23d. LOCATION (City or Town) (County) (State) Forestville Pk. George Md.
24 FUNERAL DIRECTOR Plutchin Funeral Home Currys, Md.		25a REC'D BY REGISTRAR DATE JUL 12 1967	
		25b REGISTRAR'S SIGNATURE Charles J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



FOR STATE
HEALTH DEPT.

09370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09369

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>N. Beach Md</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Louis B. Schools</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/37</u> Age (in years) <u>30</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis B. Schools</u>		14. MOTHER'S MAIDEN NAME <u>Helen Schools</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Korean</u>		16. SOC. SEC. SECURITY NO. <u>226 38 9982</u>	
17. INFORMANT <u>Mrs. Nancy R. Schools, N. Beach, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>1824</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) (c) <u>Cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had an attack and died at H</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H W Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethany Bapt. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Callao, Northumberland, Va.</u>	
24. FUNERAL DIRECTOR <u>L. P. Garrison, Jr.</u>		25. REG'D BY REGISTRAR <u>Tappahannock</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 21 1967</u>	



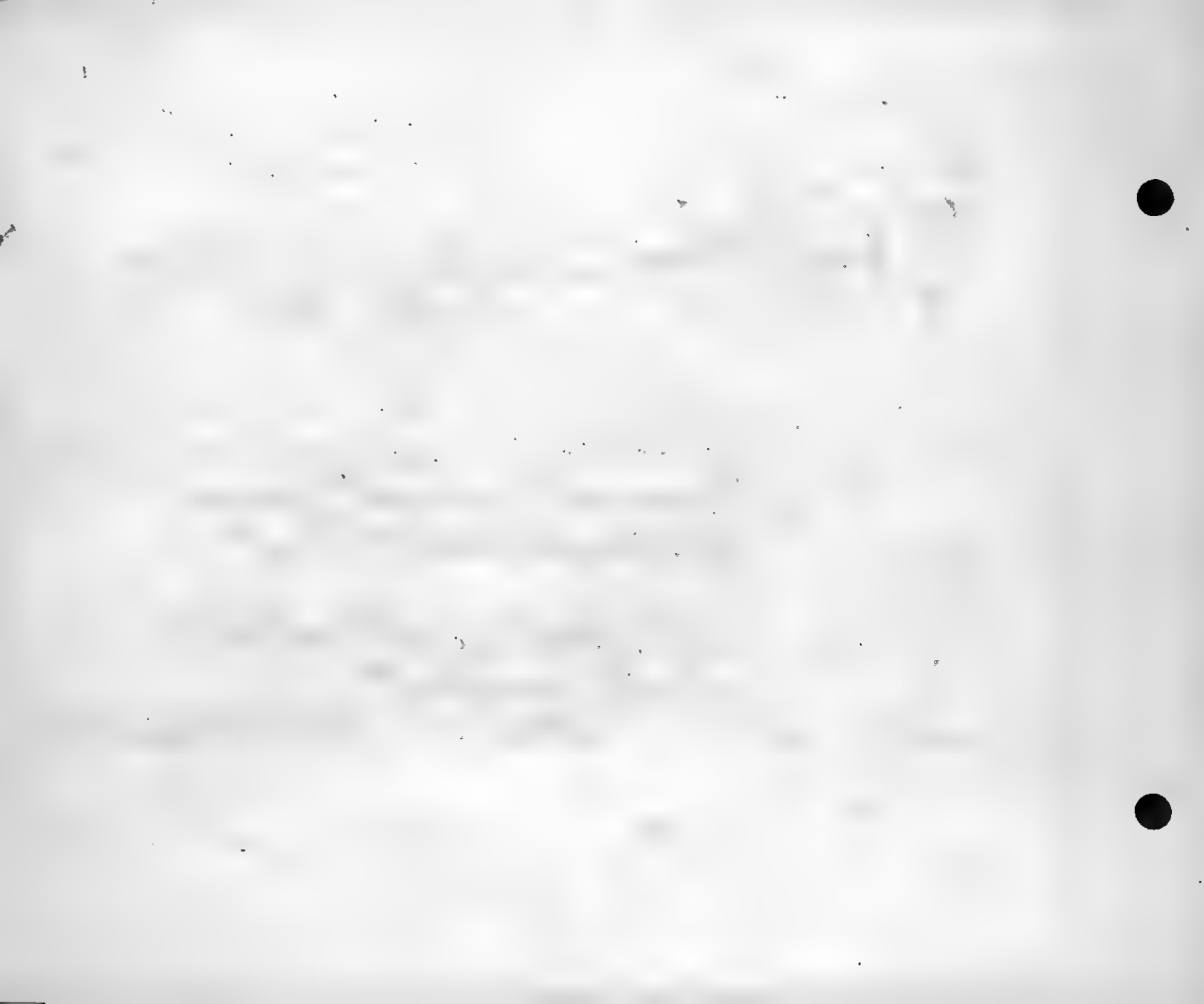
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Broomes Island</i>		c. LENGTH OF STAY IN 1b	
c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Calvert Co</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Paul Russell Sewell</i>		4. DATE OF DEATH <i>7 23 1967</i>	
5. SEX <i>M</i>	6. COLOR OF RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/11/47</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Apprentice</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>	
13. FATHER'S NAME <i>Clarence R. Sewell</i>		14. MOTHER'S MAIDEN NAME <i>Helen A. Barrett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-54-7654</i>	
17. INFORMANT <i>Clarence R. Sewell, Broomes Island, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emphysema, Broken leg, arms. Crushed Chest</i> DUE TO (b) <i>Crushed in auto. Had to be cut out by back</i> DUE TO (c) <i>Auto accident</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONS GIVEN IN PART I (c) <i>Crushed in auto. Had to be cut out by back</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>	
20c. TIME OF INJURY Month, Day, Year <i>7 23 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>#254</i>		20f. (City or town) <i>Wicomico Island Md</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. <i>H. W. Ward</i>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		22. DATE SIGNED <i>7/23/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 26, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Broomes Island Cemetery</i>		23d. LOCATION (City, town, or county) <i>Broomes Island Md.</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>A. A. Harkness, Son, Port Republic, Md.</i>		25a. REC'D BY REGISTRAR <i>JUL 27 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09372

CERTIFICATE OF DEATH

09371

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN 1b 16 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Henry Warren		4. DATE OF DEATH Month 7 Day 9 Year 19 67	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-98
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Warren, Sr.		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 228-10-1418	
17. INFORMANT Rebecca Warren		Address Mechanicsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebratory Collaps 159X DUE TO Massive Gastrointestinal Bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignancy (c) Malignancy		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 9 , 19 67 , to July 9 , 19 67 that (I) (we) last saw the deceased alive on July 9 1967, and that death occurred at 1120p , from causes and on the date stated above.			
22a. SIGNATURE Osman Z. Ersoy		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Osman Z. Ersoy		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7/24/67	23c. NAME OF CEMETERY OR CREMATORY West Med School	23d. LOCATION (City or Town) (County) (State) BALTIMORE, Md.
24. FUNERAL DIRECTOR		25a. REGD BY REGISTRAR DATE AUG 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09373

CERTIFICATE OF DEATH

09372

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS Huntingtown	
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Weaver		4. DATE OF DEATH Month July Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1889 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Weaver		14. MOTHER'S MAIDEN NAME Alice Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-03-1601	
17. INFORMANT Lillian T. Weaver, Huntingtown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X C carcinoma of prostate DUE TO (b) 2 Heart failure DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-30-67 , 19__, to 7-8-67 , 19__, that (I) (we) last saw the deceased alive on 7-8-67 , 19__, and that death occurred at 12:30 PM from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Issam El Damalouji, M.D.		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Pr. Geo., Md.
24. FUNERAL DIRECTOR F. Gasch & Sons		25a. REC'D BY REGISTRAR DATE JUL 12 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

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Calvert

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Calvert County Hospital

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250-00-1 of William V. Calvert, Hagerstown, Md.

NO

Calvert County Hospital
Calvert, Md.

1-8-67

12:00P

1-30-67

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Calvert

Calvert County Hospital, Hagerstown, Md.

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